



# Healthcare Analytics in Navy Medicine

## *Perspectives and Methods for Decision-Making*

### A CASE FOR CRITICAL THINKING

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To develop any course of action that will effect change, military medicine must have a mature analytic capability with the ability to think critically, a familiarity with the applicable subject matter, a working knowledge of military health data systems, and an expertise with analytic tools and methodologies. Of these attributes, critical thinking is paramount. This article discusses specific skills that foster critical thinking when addressing problems that face Navy Medicine.

#### Problem Interpretation and Analysis

Critical thinking begins with a reasoned evaluation of a problem. When presented with a problem, the analyst's first step in thinking critically is to interpret the problem accurately. For whom is this a problem? Why is it a problem? In what context is it a problem? A thorough understanding of the problem assures that it will be framed correctly for analysis.

To illustrate this point, let us consider the issue of spiraling healthcare costs and its relevance to military healthcare. Last year, the annual report from analysts at the Centers for Medicare and Medicaid Services projected that national health spending will climb to nearly one fifth of the gross domestic product (GDP) by 2021, with the Federal government accounting for nearly two-thirds of that total.<sup>1</sup> Without a similar rise in the growth of revenue, this growth in Federal healthcare spending, which is currently 24 percent of the total budget, will reduce the budget available for discretionary spending. Over half of the Federal government's discretionary spending is for the military.

The growth in spending on healthcare in the Department of Defense has paralleled the growth in national health spending, with healthcare spending currently accounting for about 9.5 percent of the defense budget. Healthcare spending is also the current biggest growth driver in the defense budget and has the potential to erode the Department's ability to adequately resource the programs necessary to ensure our national security. This concern led former Defense Secretary Robert Gates to remark, "Health care costs are eating the Defense Department alive."<sup>2</sup>

This contextual understanding of the problem (in this case, spiraling military healthcare costs), provides the analyst an increased likelihood of completing an analysis of action and decision alternatives that will achieve the desired outcome — managing and effectively controlling defense health spending.

For the issue under discussion, the analysis would include identifying and evaluating the potential drivers behind the increase in Defense spending for healthcare services, which can be separated into two main categories: expenditures directly related to changes in unit costs and expenditures related to changes in utilization. Potential drivers for the expenditure changes within these two categories are enumerated in Table 1.

The findings from the analysis are then further evaluated to develop recommendations for potential courses of action to achieve the desired outcomes. For the drivers of Defense healthcare spending, this evaluation would include an analysis of action and decision alternatives that most likely have the ability to effect change.

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<sup>1</sup> Health Affairs July 2012, 31:1600-1612.

<sup>2</sup> Roy, "A Real Domestic Threat: How Healthcare Spending Strains the U.S. Military, *The Atlantic*, March 12, 2012.



Although the responsibility for effecting change that will influence these drivers is shared by many Government entities, military medicine is best positioned to have a direct influence on beneficiary utilization of healthcare services and the use of direct care versus purchased care providers for supplying those services.

**Table 1. Potential drivers of Defense healthcare expenditures.**

Unit Costs	Utilization
<ul style="list-style-type: none"><li>• Inflation</li><li>• Advances in technology (i.e., more costly procedures)</li><li>• Shift in accrual accounting for TRICARE for Life</li><li>• Decrease in the beneficiary cost-share</li><li>• Shift of care from the direct care system to purchased care</li></ul>	<ul style="list-style-type: none"><li>• A growth in the TRICARE population</li><li>• Enhancement of the TRICARE benefit</li><li>• An increase in the use of healthcare services by beneficiaries<sup>3</sup></li></ul>

### Evaluating Inferences and Assumptions

In addition to problem interpretation and sound analysis, critical thinking requires the ability to evaluate the inferences and assumptions used in the analysis and underlying the conclusion for validity, reliability, and credibility. The importance of this critical thinking skill cannot be overlooked. In our example above, this type of evaluation on healthcare utilization has been exhaustively completed within the healthcare industry leading to some evidence that implementing Patient-Centered Medical Home would provide Navy Medicine the ability to better manage beneficiary healthcare utilization and outcomes that could result in the desired goal to reduce Defense health spending.

The analysis and evaluation of the drivers leading to the shift of care from the direct care system to purchased care have not been as exhaustive, however, leading to an implementation of recommended changes that may not have the same probability for success. For example, Navy Medicine's strategic initiative to recapture purchased care is predicated on the assumption that the shift of the care to the network from the direct care system is "recapturable." Further evaluation of this assumption, however, calls into question its validity. One of the drivers for this shift of care to the network was the loss of the requirement for TRICARE Standard beneficiaries to obtain approval from their military treatment facility to seek inpatient care at

civilian hospitals. The need to get a nonavailability statement (NAS) expired in 2004 under a provision of the 2002 National Defense Authorization Act. The NAS indicated that care was not available from the military facility and authorized care at a civilian facility. This 2004 policy change shifted the higher disease burden associated with TRICARE Standard beneficiaries who had been treated within the military facilities to civilian facilities, and the current access-to-care standards, set by policy that prioritizes Prime beneficiary care in the military treatment facilities, further lessens the probability that this TRICARE Standard care will be recaptured.

### Other Important Skills

Another skill considered necessary for critical thinking is the ability to clearly and coherently explain the analysis and conclusions. This skill requires the ability to truly understand the audience so that the analysis can be explained in terms they will understand. Too often the explanation is composed of complicated graphs and technical terminology that overwhelm rather than inform.

Finally, critical thinking necessitates separating oneself from the analysis and not allowing individual values and biases to influence the course of the analysis. This is the topic of another article in this issue.<sup>4</sup>

In summary, developing the skills that foster critical thinking in Navy Medicine's analytic capability will foster our ability to learn, thus enhancing our ability to discover previously hidden truths, deepen our understanding of our current situation and how we got here, and ensure that we choose the best course of action to get us where we want to be.

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## SKILLS AND METHODS

### —IMMUNIZING YOURSELF AGAINST BIAS!

*Critical thinking* is a continual process for the decision-maker and the analyst. It is easily contaminated by bias – the systematic and irrational distortion of perceived facts. Almost everyone believes themselves to be free of bias, and yet everyone has biases. Recognizing and mitigating one's biases are essential to reaching sound conclusions.

3 Gregerson, "Curing military health care" *Armed Forces Journal*, May, 2012.

4 Facione, PA, "Critical Thinking, What It is and Why It Counts", *Insight Assessment*, 1992.



While *critical thinking* might be defined in many ways, some of which contradict others, the primary originator of the term and its description, Professor Robert H. Ennis, summarizes critical thinking as “reasonable reflective thinking focused on deciding what to **believe** or **do**.” What to **believe** is a focus on what we think goes on in the world of today or the past, while what we choose to **do** combines that knowledge with what we predict will occur in the world of the future. Throughout the process of discerning the present, its causes in the past, and predicting futures based on this knowledge and management actions, critical thinkers apply many cognitive processes. These include an open-minded evaluation of other potential causes and future courses of action, a search for information that would contradict existing beliefs of facts, and using sagacious judgment on what is reasonably true, while not allowing these processes to be distorted by bias.

Much of analytic technique is based on decomposition – reducing some large aggregate phenomenon or fact into its pieces. For example, a critical analysis of cost might include looking at the cost of healthcare as an aggregate volume of a mix of different products and services, each of which may have its own volume and unit costs and result from disease prevalence, production practices, clinical management, and patient choices, all of which may be measured or estimated. Good analytic technique (and critical thinking) applies the TLAR test (“That Looks About Right”) to every component number that is measured or derived before accepting it as factual and before it loses its visibility by being embedding in some greater aggregate number.

Many analysts’ TLAR checks are based on ‘gut instinct’ – an instant reaction to a number as believable or not. Most of the time, our gut instincts are pretty good and do not misguide us, but when they are wrong, we are biased and accept as fact erroneous information. Such biases might arise from phenomena labeled and described by Daniel Kahneman, the 2002 Nobel Prize winner in economic sciences.<sup>5</sup> Some of these phenomena of bias identified by Kahneman include WYSIATI, Anchoring, and Framing.

## WYSIATI

WYSIATI is the acronym for “What You See Is All There Is”. Gut instinct will flash simultaneously across the available stored memories and facts triggered by the issue and then jump to a conclusion based only on that. This

means there are no rational cognition checks that the facts are relevant, come from a reliable source, are directly related to the issue instead of tangential, or are conclusive – all of that is skipped in gut instinct. Even those facts that the analyst knows well, possibly contradicting the conclusion, play no role in WYSIATI if they do not flash readily to mind. For example, an analyst calculates that Dr. X is 80 percent more productive than Dr. Y. The analyst likes Dr. X but has been insulted by Dr. Y. If nothing else jumps to mind, the analyst will accept this improbable result (that one physician is so much more productive than another) because his gut instinct tells him Dr. X is “the better doctor.” He may do this despite knowing, but not recalling, that both doctors work in the same clinic and have the same appointment templates (i.e., see the same number of patients for the same length appointments). This particular example also illustrates the bias from the *halo effect*, where a good or bad attribute about a person or organization is allowed to influence the judgment about other attributes unrelated to it.

## Anchoring

Anchoring causes estimates to be skewed by an available but meaningless number. For example, a recent valid study of autopsies revealed that physicians’ primary diagnoses are wrong 40 percent of the time. How often do you think physicians’ primary diagnoses are wrong in general? [Answer quickly before reading on!] Unless you rejected the autopsy study fact, you likely answered in the neighborhood of 40 percent because you were biased by the anchor provided. If the analyst quickly answers from the gut, rather than thinking through whether the anchor has relevance, any estimate or TLAR check will be biased. In this example, the autopsy findings are not relevant to this broader question on physician diagnoses in general – autopsies are rare and are heavily skewed towards deaths that were unexpected or towards those where the patient did not respond to normal therapies without an apparent reason. Naturally, such cases will often reveal new information about the patient unknown to the physician. After exposure to anchoring information, the analyst must try to get the anchor completely out-of-mind before making the estimate; however, this is not easy to do because of the WYSIATI phenomenon described above.

## Framing

Framing warps judgment by its use of loaded terms or context. For example, many military metrics about purchased healthcare use the term *leakage*, which has

<sup>5</sup> A much more thorough and expanded coverage of Daniel Kahneman’s work can be found in his book, [Thinking, Fast and Slow](#).



a heavy connotation of something you do not want to happen. *Recapture* has the flavor of a good thing: success in corralling a beast that has escaped. But an analyst evaluating care sources and the optimum integration of direct and purchased care should view these issues as *make-or-buy*, or *insourcing vs. outsourcing*, to avoid conscious or unconscious skewing of data to favor the side framed with the positive term. A similar effect occurs in clinical medicine. The proportion of patients who will consent to a procedure is dramatically higher if it is framed as having a 50 percent chance of saving the patient, rather than if the clinician says there is a 50 percent chance of dying from it. *Saving* is a positive term, while *dying* is generally a negative term. Avoid bias by recognizing framing and then, restating the question in neutral terms.

Expert analysts employ critical thinking throughout their work. All critical thinkers must immunize themselves against bias by staying alert for biasing situations and mitigating the bias impact when they arise.

## DATA AND INFORMATION SYSTEMS

### —HEALTH SCIENCES LIBRARY SERVICES

This article outlines the registration process and available resources for the service specific electronic library systems available to both DoD personnel and contractors supporting medical department facilities.

The healthcare field is perpetually evolving and thus requiring increasing levels of critical thinking and analysis. Peer-reviewed literature can be helpful in evaluating the potential impact of policy or practice changes or engendering more efficient methodologies in both the clinical and business milieus, as it provides a factual knowledge base to which critical thinking and problem solving can be applied. Peer-reviewed journals serve as great resources of current methodologies and discussions on improving health and healthcare that can be incorporated in analyses throughout the MHS.

The Navy, Army, and Air Force each has electronic library services available to those employees and contractors who work with or support the mission of medical treatment facilities. These services include research institutes and laboratories, environmental health centers, disease vector centers, training activities, occupational health and prevention medicine units, and information management centers. Once registered for these services, an individual has access to them from on- and off-site

duty locations. These services also include opportunities to obtain Continuing Education (CE) or Continuing Medical Education (CME) credits. Certain personnel can acquire CE and CME credits through programs such as UpToDate, MD Consult, Medscape or from individual journals, like the Journal of American Medical Association (JAMA). Contact your CE/CME point of contact for more information.

Below is a brief description of the Navy, Air Force, and Army's library services, which consist of licensed databases, e-books, and e-journals supporting clinical and best business practices for the MHS medical, dental and veterinary medicine staff. Some databases contain either whole article(s) files for download and/or brief summaries or abstracts and reference information, which includes the title, author(s), journal (volume and issue if applicable), and year of publication. If the article is not available online but is physically available in any of the libraries in the system, then it can be requested and sent via e-mail.

### Navy Medicine Electronic Library

To register with Navy Medicine Electronic Library (NMEL) go to <https://register.athensams.net/nav/> and follow the instructions on the page. Note that a "navy.med.mil" e-mail is necessary to register. Otherwise, contact the listed "Navy Medicine Electronic Library" POC to set up an account with a non-"navy.med.mil" e-mail address. A sample of NMEL's resources includes EBSCO host databases, Lexi-Comp, MD Consult, Mosby's Nursing Skills, Ovid Online, STAT!Ref, PubMed, and several full-text e-journals.

### Air Force Medical Service Knowledge Exchange

To register with Air Force Medical Service Knowledge Exchange (AFMS KX) go to <https://kx.afms.mil>. A CAC is necessary to access the website and register. There are two levels of registration: "Full Membership" and "Sponsored Membership." Only members of the AFMS community (with a valid .mil account) are eligible for "Full Membership." The "Sponsored Membership" is for CAC holders who are not members of AFMS but are working directly with the manager of a specific organization or specialty community within the Knowledge Exchange. Once on the homepage, click on "Join the KX!" link in the lower left panel and choose the applicable membership level. Resources in the AFMS KX include UpToDate, OvidTechnologies, MD Consult, Nursing Consult, DOSS,





EBSCO host databases, MEDLINE, CINAHL, Journals Consult, Lexicomp, PubMed, and Stat!Ref.

### Army Medical Department (AMEDD) Virtual Library

To register with AMEDD Virtual Library (AVL) go to <https://register.athensams.net/amedd/> and follow instructions on the page. Note that the appropriate “us.army.mil” or “mail.mil” e-mail is necessary to register. Otherwise, contact the listed “AVL Athens Administrator” POC to set up an account with a non-“.mil” e-mail address. The AMEDD AVL e-resources include: CINAHL, Dentistry & Oral Sciences Source, Lexi-Comp, MD Consult, MDGuidelines, MedlinePlus, Natural Medicines Comprehensive Database, Nursing Consult, Ovid, MEDLINE, PsycINFO, Evidence-Based Medicine Reviews, PubMed, STAT!Ref, UpToDate, and several full-text e-journals.

## NEW KNOWLEDGE

### —KAISER FAMILY FOUNDATION STATE HEALTH FACTS

Many analysts are interested in how the MHS compares to the civilian sector. One useful resource for making such comparisons is the Kaiser Family Foundation State Health Facts website. The website provides, at state and national levels, various demographic, health status and health coverage data.

The State Health Facts website (<http://www.state-healthfacts.org/index.jsp>) is designed to “provide free, up-to-date, and easy-to-use health data,” and is a project of the Henry J. Kaiser Family Foundation.<sup>6</sup> The State Health Facts website is fed by data from multiple sources including the Census Bureau’s Current Population Surveys (CPS) and the Annual Social and Economic Supplement (ASEC), the American Community Survey (ACS), the Centers for Medicare and Medicaid Services (CMS), and the National Center for Veterans Analysis and Statistics (NCVAS). Note that the CPS is restricted to the civilian (non-active duty military) population.

### Available Data

The website provides several major categories of data, with elements of interest highlighted below:

- Demographics and the Economy
  - Distribution by Age
  - Distribution by Gender
  - Distribution by Race/Ethnicity
  - Veteran Population
- Health Status
  - Birth Rate
  - Childhood and Adult Immunizations
  - Death Rate
  - Various conditions including colorectal cancer, diabetes, heart disease, smoking, asthma, obesity, mental health, and suicides
- Health Costs & Budgets
  - Health Spending by Service (Hospital Care, Physician Services, Prescription Drugs, etc.)
  - Total Retail Prescription Drugs
  - Expenses per Inpatient Day
- Providers & Service Use
  - Total Hospitals and Number of Beds
  - Admissions
  - Emergency Room Visits
  - Outpatient Visits
  - Total Active Physicians (by gender, field, and specialty area)
  - Non-Physician Providers (Registered Nurses, Physician Assistants, Nurse Practitioners)
- Additional categories of available statistics include Medicaid & CHIP, Medicare, Minority Health, Women’s Health, and HIV/AIDS

### A Word of Caution

When comparing MHS data to civilian sector data, it is always important to keep in mind the differences between the TRICARE-eligible population and the civilian population. For example, the Prime-enrolled population tends to be younger and healthier than the average civilian population, which includes Medicaid and/or Medicare-eligible individuals, as well as uninsured individuals. Due to deployments, the active duty population also tends to have higher trauma and injury rates (including TBI) and a higher incidence of mental health issues. Additionally, women of child-bearing age in our TRICARE-eligible population are more likely to be married, as compared to the civilian population, and may have differing birth rates than some segments of a comparable civilian population

6 <http://www.statehealthfacts.org/about.jsp>



(e.g., privately-insured, uninsured, Medicaid-eligible). Understanding the differences in the two populations can help explain observed differences in the healthcare data of TRICARE-eligible and civilian populations.

## WHAT'S COMING UP

### Upcoming Fixes to CAPER Cost Data

For some product lines, direct care cost data in the Comprehensive Ambulatory/Professional Encounter Record (CAPER) for FY 2010 forward are significantly different than cost data obtained for these same years before a revision of the Patient Level Cost Allocation (PLCA) costing methodology was applied to the CAPER in 2012. The new PLCA costing methodology was implemented for only FY2010 forward, and an evaluation of pre- and post-implementation cost discrepancies found that three key factors account for the change in direct care costs for FY 2010 forward:

- **An update of the base year for PLCA.** The PLCA method takes the total Medical Expense & Performance Reporting System (MEPRS) expenses for a given Military Treatment Facility (MTF) and allocates it among each record from that MTF. It takes some time for the MEPRS data to become complete and for the PLCA process to finish, resulting in a delay of about a year before a given year of data is costed with that same year of MEPRS data (e.g., FY 2012 data in the MDR will not be costed with FY 2012 MEPRS data until about August 2013). Until that time, unit costs from previous years of MEPRS data are inflated and applied to future years' workload records as part of the normal PLCA allocation process; however, these projections can over- or underestimate actual direct care costs in the most recent years. For example, prior to March 2012, both FY 2010 and FY 2011 data were costed with FY 2009 MEPRS data, and it was found that the projection of the FY09 MEPRS data overestimated the actual direct care cost in FY 2010 and in FY 2011.
- **A change in the way that Relative Value Units (RVUs) are applied to the CAPER.** MTF costs are allocated based on workload, but unlike earlier data, a significant portion of costs on CAPERs are now allocated using the Provider Aggregate Total RVU. The revised PLCA cost allocation method discounts RVUs for non-physician providers, where they had previously received the same RVU credit as physicians, in addition to discount-

ing for many procedures that are done within a single encounter. These changes, particularly the change to Provider Aggregate Total RVU, have had a large effect on direct care cost derivation, especially among clinics that rely heavily on non-physician providers

- **A new ancillary cost allocation method.** MTF ancillary costs have previously been pooled together at the MTF level and allocated ("stepped down") across all clinics evenly. As a result, clinics that did relatively little ancillary workload received stepdown costs that were too high, and clinics that did relatively more ancillary workload received stepdown costs that were too low. Starting with FY 2010 data, the revised PLCA method now allocates ancillary costs based on the actual ancillary workload. Consequently, clinics with very little ancillary workload had a decrease in direct care costs after FY 2010, while clinics with higher ancillary workload had an increase in direct care costs after FY 2010.

In summary, any analysis with direct care cost trending that crosses from FY 2009 to FY 2010 will not yield an accurate result and should be interpreted with caution. As a result, costs will soon be retroactively allocated to FY 2008 and FY 2009 CAPERs in the MHS Data Repository (MDR) using the revised PLCA method. The same fix will be made to M2 CAPER files before the end of the year.

## TIPS AND TRICKS

### —DATA ANALYSIS TOOLPAK IN EXCEL

The Data Analysis ToolPak in Excel allows the user to perform complex statistical analyses by inputting data and parameters. This article provides an overview of this Excel feature and examples of some of the tools available. Additional tools in the Data Analysis ToolPak will be featured in upcoming issues of this publication.

The Data Analysis ToolPak is useful for both simple and complicated analyses. The Data Analysis ToolPak (figure 1) offers a wide variety of analytical tools including: Anova, Correlation, Covariance, Descriptive Statistics, Exponential Smoothing, F-Test Two-Sample for Variances, Fourier Analysis, Histogram, Moving Average, Random Number Generation, Rank and Percentile, Regression, Sampling, t-Test, and z-Tests. The "Help" button has a definition for every tool. Note that some tools can produce both numeric and chart output (e.g., Histograms). The Data Analysis Package in Excel can be

found in the DATA ribbon under “Analysis”. If you do not have the Data Analysis ToolPak, go to “File” / “Options” / “Add-Ins” and double-click on Analysis ToolPak; it should then appear under the DATA ribbon.

### Data Analysis ToolPak: Descriptive Statistics

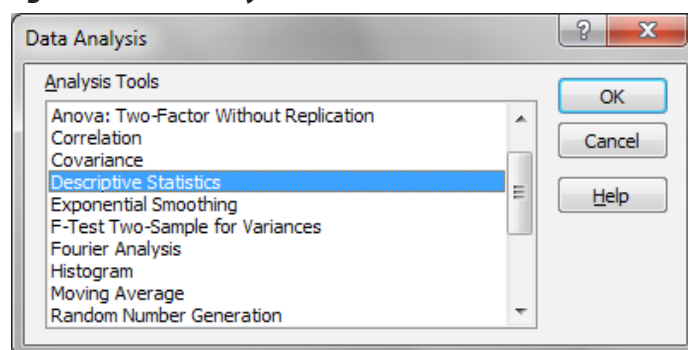
Descriptive Statistics is a great tool to learn about your data. If you have inpatient costs across hospitals in the same peer group for a given fiscal year, then it might be helpful to know the mean cost across all hospitals, as well as the mode, minimum, and maximum of the costs, which can all be easily produced by this tool. While these functions exist independently in excel (e.g., the AVERAGE function in Excel outputs the mean of the designated cells), the Descriptive Statistics tool in the Data Analysis ToolPak produces means, standard deviations, skewness, range, and many more descriptive statistics all at once.

To access this tool, select the DATA ribbon, “Data Analysis” and “Descriptive Statistics” (figure 2). An input range is required and should include only the cells that contain the measures of interest. In other words, if you pulled costs of inpatient hospitals from M2, then do not include that column of DMIS IDs in the “Input Range”. If the first cell in the column has a label (e.g., Full Cost), then select “Label in first row”. There are multiple output options. If the output of the Descriptive Statistics is desired on the same sheet as the input data, then just select one cell on the worksheet, which will become the upper left-hand corner of the output display. There are additional statistics listed at the bottom.

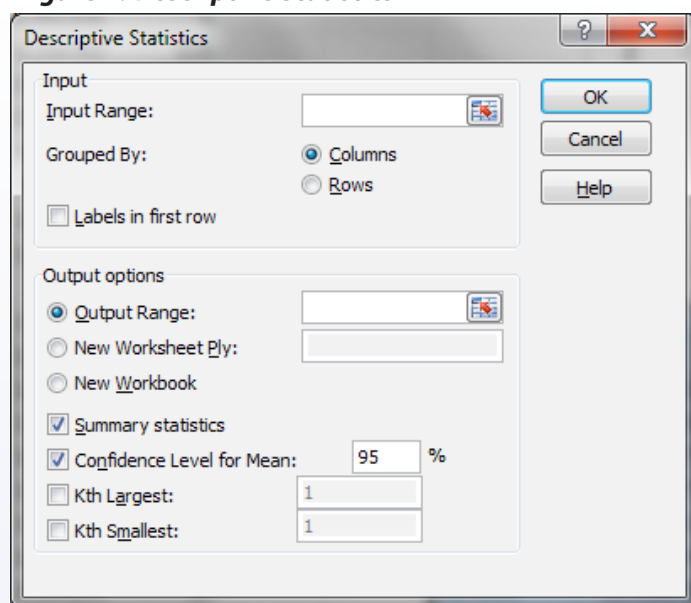
### Data Analysis ToolPak: Sampling

Another great tool in the Data Analysis ToolPak is Sampling. To access this tool, select the DATA ribbon, “Data Analysis” and “Sampling” (figure 3). The Sampling tool enables the user to take either a periodic or random sample from a dataset. In a periodic sample, a period is specified, such as “Period: 2”, which would return every other observation from the dataset. The random sample is a great way to accommodate the row limit in M2. If you are pulling record-level data for patients at a large MTF or for a population of interest (e.g., diabetics), you can maintain a complete list of encrypted person identifiers (i.e., Pseudo Person ID) for that population in Excel but create a random sample of patients for whom you can pull record-level data from M2 and perform analysis. Like

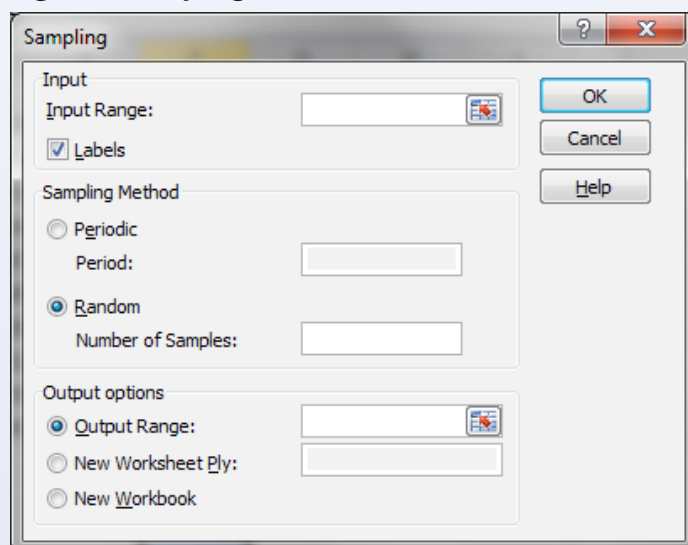
**Figure 1. Data Analysis ToolPak**



**Figure 2. Descriptive Statistics**



**Figure 3. Sampling**





Descriptive Statistics, the Sampling tool has an Input Range, where in the example above all Pseudo Person IDs would be selected and “Labels” clicked if applicable. For the “Sampling Method,” select “Random” and enter the number desired in the sample. Lastly, the user has to specify output options. If the sample will be uploaded into M2 via the External Data Provider function (see Volume 2, Issue 3, *Focus on Medical Management*), then outputting to a new Excel worksheet or workbook will be the most straightforward. Also, remember to reformat the column of the generated sample as text before uploading it into M2; otherwise, M2 will read the data as numeric instead of character.

To read more about the Data Analysis ToolPak, visit the Microsoft Support webpage at <http://office.microsoft.com/en-us/excel-help/use-the-analysis-toolpak-to-perform-complex-data-analysis-HA102748996.aspx>. For more basic information, select the “Help” button available for each tool.

## KNOWLEDGE SOURCES

### —HEALTHCARE-RELATED BLOGS

Upcoming issues of *Healthcare Analytics in Navy Medicine* will highlight prominent health blogs as a new addition to this section. Below is an informative blog featuring commentary on healthcare and industry issues useful for professional growth and development.

The *Health Affairs* Blog ([healthaffairs.org/blog/](http://healthaffairs.org/blog/)) offers a daily commentary on vital issues in health policy from contributors to *Health Affairs*, a prominent industry publication, as well as policy experts from both sides of the political aisle. The topics discussed in the blog are divided into categories (e.g., Access to Care, Global Health, Chronic Care, Payment, Policy, Mental Health, etc.), allowing the reader to easily locate his or her area(s) of interest and join in the conversation. The ‘Blogroll’ also links to other blogs discussing health policy. The *Health Affairs* blog is a great alternative for those who do not have a subscription to *Health Affairs* but enjoy reading about or participating in stimulating discussions regarding all health care topics.

## IN THE NEXT ISSUE

The next issue of *Healthcare Analytics in Navy Medicine* will focus on identifying and quantifying dental care delivered by Navy Medicine and TRICARE to its beneficiaries. The provision of dental care is a fundamental mission to ensure the readiness of Active Duty Service Members. The next issue will highlight current policy and practice issues related to dental care and feature skills and tools available to analysts to address these issues.

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